



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

TROPHY CLUB MEDICAL CENTER
2850 E STATE HWY 114
TROPHY CLUB, TX 76262

Respondent Name

SOMPO JAPAN INSURANCE CO OF AM

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-13-2049-01

MFDR Date Received

April 15, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We are in receipt of your Explanation of Benefits for payments totaling \$23,694.46, please be advised of We are in receipt of your Explanation of Benefits for payments totaling \$23,694.46, please be advised of the following:

TDI Commission Rule §134.403, section (f)(1) states that: the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment shall be multiplied by:

A. 143%, **UNLESS**

B. **Facility request separate reimbursement for implants as specified in subsection (g), in which case shall be multiplied by 108% ...** Implants accounted for a total cost of \$41,980.09 with a 10% mark up equivalent to \$2,000.00, totaling to an implant allowance of \$43,980.09 for these services; **(implant invoices and certification provided at time of bill)** in addition to we requesting 108% of Medicare APC equivalent to \$22,949.63 for a cumulative total of \$66,929.72. Less the payments received of \$23,694.46; we are rightfully owed \$43,235.26."

Amount in Dispute: \$12,825.48

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: No response received from the carrier

Response Submitted by: N/A

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 07, 2012 to November 10, 2012	Inpatient Hospital Surgical Services	\$12,825.48	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 amended to be effective May 31, 2012, 37 *Texas Register*

3833, applicable to medical fee dispute resolution requests filed on or after June 1, 2012, sets out the procedures for resolving a medical fee dispute.

2. 28 Texas Administrative Code §134.404 sets out the guidelines for reimbursement of hospital facility fees for inpatient services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated December 31, 2012

- 5 – The procedure code/bill type is inconsistent with the place of service.
- W1 – Workers' compensation jurisdictional fee schedule adjustment

Explanation of benefits dated March 20, 2013

- W1 – Workers' compensation jurisdictional fee schedule adjustment
- W1 – Workers' compensation jurisdictional fee schedule adjustment
- 5 – The procedure code/bill type is inconsistent with the place of service

Issues

1. Were the disputed services subject to a specific fee schedule set in a contract between the parties that complies with the requirements of Labor Code §413.011?
2. Which reimbursement calculation applies to the services in dispute?
3. What is the maximum allowable reimbursement for the services in dispute?
4. Is the requestor entitled to additional reimbursement for the disputed services?

Findings

1. 28 Texas Administrative Code §134.404(e) states that: "Except as provided in subsection (h) of this section, regardless of billed amount, reimbursement shall be:
 - (1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code §413.011; or
 - (2) if no contracted fee schedule exists that complies with Labor Code §413.011, the maximum allowable reimbursement (MAR) amount under subsection (f) of this section, including any applicable outlier payment amounts and reimbursement for implantables."

No documentation was found to support the existence of a contractual agreement between the parties to this dispute; therefore the MAR can be established under §134.404(f).

2. §134.404(f) states that "The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.
 - (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
 - (A) 143 percent; unless
 - (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 108 percent."
3. §134.404(f)(1)(A) establishes MAR by multiplying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors (including outliers) by 143%. Information regarding the calculation of Medicare IPPS payment rates may be found at <http://www.cms.gov>. Documentation found supports that the DRG assigned to the services in dispute is 460, and that the services were provided at Trophy Club Medical Center. Consideration of the DRG, location of the services, and bill-specific information results in a total Medicare facility specific allowable amount of \$22,098.32. This amount multiplied by 143% results in a MAR of \$31,600.60.
4. The division concludes that the total allowable reimbursement for the services in dispute is \$31,600.60. The respondent issued payment in the amount of \$54,645.34. Based upon the documentation submitted, no additional reimbursement is recommended.

Conclusion

For the reasons stated above, the division finds that no additional reimbursement is due.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

8/30/13

Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-481.